

LUSKIN, STERN & EISLER LLP  
Eleven Times Square  
New York, New York 10036  
Telephone: (212) 597-8200  
Facsimile: (212) 974-3205  
Michael Luskin  
Stephan E. Hornung

*Attorneys for Kathleen Kime*

**UNITED STATES BANKRUPTCY COURT  
SOUTHERN DISTRICT OF NEW YORK**

In re:

SEARS HOLDINGS CORPORATION, *et al.*,

Debtors.<sup>1</sup>

Chapter 11

Case No. 18-23538 (RDD)

(Jointly Administered)

**DECLARATION OF KATHLEEN KIME IN SUPPORT OF  
MOTION TO DEEM PROOFS OF CLAIM AS TIMELY FILED  
AND FOR RELIEF FROM THE AUTOMATIC STAY**

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<sup>1</sup> The Debtors in these chapter 11 cases, along with the last four digits of each Debtor's federal tax identification number, are as follows: Sears Holdings Corporation (0798); Kmart Holding Corporation (3116); Kmart Operations LLC (6546); Sears Operations LLC (4331); Sears, Roebuck and Co. (0680); ServiceLive Inc. (6774); SHC Licensed Business LLC (3718); A&E Factory Service, LLC (6695); A&E Home Delivery, LLC (0205); A&E Lawn & Garden, LLC (5028); A&E Signature Service, LLC (0204); FBA Holdings Inc. (6537); Innovel Solutions, Inc. (7180); Kmart Corporation (9500); MaxServ, Inc. (7626); Private Brands, Ltd. (4022); Sears Development Co. (6028); Sears Holdings Management Corporation (2148); Sears Home & Business Franchises, Inc. (6742); Sears Home Improvement Products, Inc. (8591); Sears Insurance Services, L.L.C. (7182); Sears Procurement Services, Inc. (2859); Sears Protection Company (1250); Sears Protection Company (PR) Inc. (4861); Sears Roebuck Acceptance Corp. (0535); SR – Rover de Puerto Rico, LLC (f/k/a Sears, Roebuck de Puerto Rico, Inc.) (3626); SYW Relay LLC (1870); Wally Labs LLC (None); SHC Promotions LLC (9626); Big Beaver of Florida Development, LLC (None); California Builder Appliances, Inc. (6327); Florida Builder Appliances, Inc. (9133); KBL Holding Inc. (1295); KLC, Inc. (0839); Kmart of Michigan, Inc. (1696); Kmart of Washington LLC (8898); Kmart Shores of Illinois LLC (8897); Kmart Stores of Texas LLC (8915); MyGofer LLC (5531); Sears Brands Business Unit Corporation (4658); Sears Holdings Publishing Company, LLC (5554); Sears Protection Company (Florida), L.L.C. (4239); SHC Desert Springs, LLC (None); SOE, Inc. (9616); StarWest, LLC (5379); STI Merchandising, Inc. (0188); Troy Coolidge No. 13, LLC (None); BlueLight.com, Inc. (7034); Sears Brands, L.L.C. (4664); Sears Buying Services, Inc. (6533); Kmart.com LLC (9022); and Sears Brands Management Corporation (5365). The location of the Debtors' corporate headquarters is 3333 Beverly Road, Hoffman Estates, Illinois 60179.

I, Kathleen Kime, declare as follows:

1. I am the plaintiff in a personal injury action against Sears Holdings Management Corporation, A&E Factory Services, LLC (“A&E Factory Services”), and Gregory Williams.

2. I submit this declaration in support of my motion to deem my proofs of claim as timely filed and for relief from the automatic stay. I make this declaration based on my own personal knowledge and could testify competently regarding these facts if called to do so.

3. I was injured in a motor vehicle collision on June 14, 2016 when a vehicle operated by Gregory Williams rear-ended my vehicle. Mr. Williams and I exchanged information at the scene of the accident. Mr. Williams was driving an A&E Factory Services vehicle registered to the same and told me that he was on a service call at the time of the incident. He asked me not to call the police. At the scene, and in my presence, Mr. Williams called his employer and reported the incident and the fact that he was at fault. Mr. Williams and I then completed an incident report form he produced from his vehicle at the scene. A picture of the incident form is attached as Exhibit 1.

4. On or about June 15, 2016, Janet Cozzone at Sedgwick Claims Management Services, Inc. (“Sedgwick”), the claims adjuster representing the Debtors for this claim called me. I was advised that Sedgwick was representing the insurance carrier for defendant Gregory Williams’ employer, A&E Factory Services. I provided information to Ms. Cozzone concerning the facts of the incident and my symptoms and injuries at the time. I was given a claim number and directed to contact Sedgwick concerning my claim. I made notes during the conversation. A true and correct copy of my notes is attached as Exhibit 2.

5. Shortly thereafter, Sedgwick arranged for a vehicle property damage inspection of my vehicle at a local auto body shop. I exchanged email correspondence with Sedgwick concerning my property damage claim.

6. I received a letter from Janet Cozzone at Sedgwick dated June 21, 2016, advising me about certain Medicare and Medicaid mandatory reporting requirements concerning beneficiaries who receive settlements, judgments, awards, or other payment from liability insurance, no-fault insurance, or workers' compensation and requested that I complete a questionnaire for that purpose. A true and correct copy of the Medicare and Medicaid form is attached as **Exhibit 3.**

7. I received another letter from Janet Cozzone at Sedgwick dated June 21, 2016 requesting that I complete an authorization to allow Sedgwick to verify my wage information with my employer. A true and correct copy of the authorization is attached as **Exhibit 4.**

8. I received another letter from Janet Cozzone at Sedgwick dated June 21, 2016 requesting that I complete a medical authorization to allow Sedgwick to obtain my medical documentation from the hospital and/or doctor(s) that treated me in connection with the incident. This letter also advised me that Sedgwick manages claims for Sears Holdings Corporation on behalf of ACE American Insurance Company. A true and correct copy of the medical authorization is attached as **Exhibit 5.**

9. In July 2016, I retained William A. Deitchman, Esq. to represent me in my personal injury claim in connection with the accident.

10. In July and August, 2016, I corresponded with Janet Cozzone at Sedgwick concerning my property damage claim. I settled my property damage claim and signed a release with my attorney's modification of the release, which expressly excluded my personal injury claim. A true and correct copy of the release is attached as **Exhibit 6.**

11. I received a letter from ESIS AGL Claims dated November 6, 2018, notifying me that it represents defendant, Sears Holdings Corporation, and requesting that I complete a

questionnaire for Medicare reporting purposes. This letter was sent certified with return receipt requested. A true and correct copy of the November 6, 2018 letter is attached as **Exhibit 7**.

12. I did not receive any written notice of the Debtors' bankruptcy or of the bar date, from the Debtors, their insurer carrier, or the claims adjuster.

13. I learned of the Debtors' bankruptcy case and bar date on August 13, 2019 from my attorney.

14. Had I received notice from Sedgwick or the Debtors about the bankruptcy filing and the bar date, I would have contacted my attorney immediately and taken steps to timely file a proof of claim to preserve my personal injury claim against the Debtors.

15. This incident has had a devastating impact on my life. After the rear-end collision, I had an immediate onset of severe head pain, jaw pain, neck pain, upper and lower back pain, and left shoulder pain. Two days after the incident I saw Leanne Camisa, M.D., my family doctor, who diagnosed me with a concussion (I was having excruciating head pain, dizziness, and vision problems which would last months) and cervical radiculopathy. Dr. Camisa ordered a brain MRI. When my neck and back pain failed to improve over the next few weeks, I started chiropractic treatment and physical therapy. Several months later, I had MRIs of my neck, lower back and left shoulder because I was still having terrible pain. My chiropractor referred me to Philip Orisek, M.D., an orthopedic spine surgeon. Dr. Orisek ordered a new MRI of my cervical spine and diagnosed me with a large disc herniation at C6-7, a left-sided protrusion at C5-6, and upper extremity radiculopathy. Dr. Orisek referred me to Amir Jamali, M.D., an orthopedic surgeon who treated my left shoulder injury and performed surgery on October 29, 2018. Dr. Orisek recently performed surgery on my spine at C5-7 with disk replacements of C5-C6 and C6-C7 on June 18, 2019. Both Dr. Orisek and Dr. Jamali attributed

my injuries and need for surgery to the motor vehicle collision on June 14, 2016. I am currently in post-surgical physical therapy for my neck. My neck and left shoulder symptoms are slowly improving and I take pain killers, use heat and ice, and avoid aggravating activities. Unfortunately, I still have pain in two molars, but I do not have dental insurance to fix them. I also have the same lower back pain from a herniated disc that showed up on the MRI, but I am afraid of having back surgery at the moment.

16. My surgeries, and particularly the neck surgery, were frightening to have. However, the prospect of not having the surgeries was far worse. Before my surgeries, I had constant neck and left shoulder pain that interfered with my ability to do normal activities of daily living and diminished my quality and enjoyment of life. I was an active person before this collision. I enjoyed hiking, jogging, yoga, dancing, exercising, fishing, and horseback riding. I loved my home and took pride in my ability to keep it nice and well cared for. I did all of my own household chores and yard work. I lived alone and was self-reliant. I also enjoyed entertaining friends and family and socializing.

17. Because of my painful injuries, I was unable to hike or jog or take long walks because the swinging motion of my arms hurt my shoulders, neck and back. In yoga, I was unable to hold myself in “plank” position or nearly any other position. I belonged to a horse share-a-friend program but could no longer participate in it because the pain of riding a horse was unbearable. I was unable to go fishing with my son because casting the pole was painful. At home, I struggled with everyday chores such as cleaning, doing laundry, loading and unloading the dishwasher, taking out the trash, picking up anything off of the floor and even grocery shopping. My yard became a mess because I was unable to mow, pull weeds, rake, sweep the patio, water plants, or do gardening work. I missed numerous engagements, invites,

and parties with family and friends. I spent less time with my son, Jared, and have been less help, which put a strain on our relationship. Jared was married last August and, due to pain from my injuries and being financially devastated, I was not able to be the help at the wedding that I wanted to be, which was particularly hard on us and hard on my pride. He is my only son and we have always been close. I relied on his help after the surgeries but have been unable to do the many things that we used to enjoy doing together. I feel like I am not there for him like I should be. I feel like I have an almost non-existent social life; I have missed so many family events and events with friends. Prior to the incident, I was always a very social, happy, and active person. This isolation made me feel lonely, depressed, and anxious about the future.

18. I have spent countless hours driving to and from doctor appointments. The cost for co-pays, gas, and wear and tear on my vehicle have also taken a financial toll on me, especially since I have had no regular employment since the incident occurred. Immediately following the incident and as a result of my injuries, I had to leave my job as a Montessori teacher, program director, and office manager. Since then, I have been doing the best I can to manage financially, but I have only just scraped by even with the help of my family. I have approximately \$20,000 in credit card debt that has accrued because I am paying my utilities and bills with my credit cards. I have over \$121,000 in medical expenses for my medical treatment, not including the hospital charges for my recent neck surgery. These unpaid bills are very alarming to me.

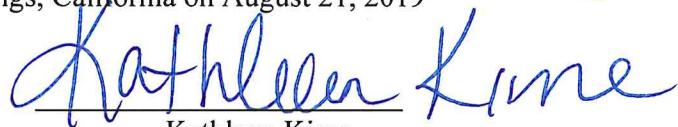
19. I struggle to make my house payment and fear losing my home and being homeless. I bought my home when I was 30 years old by myself and I have taken great pride in that fact. I have never missed a payment or been late on a payment, and I have struggled to keep the victory going. My financial situation has affected my ability to do upkeep on my home. My

washer and dryer broke during this time. It has been a couple of years post-accident and I have had no functioning washer or dryer. There are tons of needed repairs and upkeep in my house that have not been done. The yard is totally and embarrassingly overgrown and out of control; I even have neighbors making comments about it and I cannot do anything about it. My garbage disposal broke; I have had plumbing issues in my kitchen and bathroom and I have no one to hire or help. I want to fix these things. Now, I am beyond devastated about the disrepair and ruin of my home, my yard, my finances, and my vehicles (my prized Toyota pickup truck that I bought myself in 1997 is not running, has a dead battery, and has tires that cannot be driven upon). This is a first in my life. I have always maintained my Toyota pickup and it is now completely a permanent fixture in my wisteria-vine infested driveway. There are even notes on my pickup from neighbors who have noticed that it is sitting in my driveway and want to buy it. I will never sell it, but it is beyond embarrassing that people see it sitting there and think it is being neglected, which it is. I have not been able to afford the Internet and, therefore, it is difficult for me to do a comprehensive job search, send resumes via email, complete on-line applications, etc. These things have been a constant source of stress and worry.

20. The accumulated pain, mental and emotion stress, and daily challenge of living normally, have led to depression which I am still managing. I have had and continue to have many sleepless nights because of the pain and constant worry. I feel like this incident has robbed me of financial, emotional, and physical stability. However, now that I completed my neck surgery and my symptoms are improving, I am able to return to work and I'm actively looking for full time employment. I am working towards being my normal self again.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed in Diamond Springs, California on August 21, 2019

  
Kathleen Kime

# EXHIBIT 1

**GET THE FACTS** After taking photos, complete ALL SECTIONS of this Accident Summary before leaving the scene.

# EXHIBIT 2

Motions Eyes having trouble vision  
Next? HEAD immediately  
Dwags? NECK immediately  
P+ Shoulder

Cracking Upper lower back  
ache jaw immedi  
ached teeth immediatley  
hurt

" Sedwick 3rd Party  
1-800-737-0121 FOR SEARS

Vehicle Car # A 1606155080  
injury Photos Estimate Repair 0002  
# A 1606155080 -  
Registration 0003.

Examiner Assigned  
1-866-352-1521

Page 876-7050  
John

Id: 30

Sedgwick Janet follow-up Date 02/07/19  
866 352 1521 e mail: [kathleen.kime@sedgwick.com](mailto:kathleen.kime@sedgwick.com)  
X 50694  
File # 1606155080

# EXHIBIT 3

Sedgwick Claims Management Services, Inc.  
P O Box 14448  
Lexington, KY 40512-4448



Phone: (866)352-1521

Fax: (866)876-7050

June 21, 2016

Kathie Kime  
417 Cappella Drive  
Diamond Springs CA 95619

Re: Kathie Kime  
Sedgwick file number: A1606155080-0003  
Medicare mandatory reporting

Dear Kathie Kime

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements with respect to Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance, no-fault insurance, or workers' compensation. Accordingly, we must collect the information on the attached form to determine if we are required to report this claim pursuant to the MMSEA requirements.

Please complete Sections I and II of the enclosed form and return it to me. If you are unwilling to provide your complete Social Security Number, it is acceptable for you to provide the last 5 digits. If you are unwilling to provide any Social Security information, please complete Section III only and provide your reasoning in the space provided. Make sure you have signed the form before returning it to me.

If you have questions about this form or the MMSEA please go to: <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html> or contact the Benefits Coordination & Recovery Center (BCRC). BCRC Customer Service Representatives are available to assist you Monday through Friday, from 8:00 a.m. to 8:00 p.m., Eastern Time, except holidays, at toll-free lines: 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

Thank you for your anticipated cooperation.

Janet Cozzone  
Claims Representative

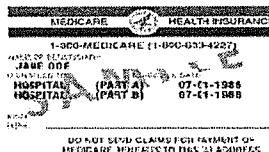
Return to:  
Janet Cozzone  
P O Box 14448 Lexington, KY 40512-4448

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



DO NOT SEND CLAIMS FOR PAYMENT OR  
MEDICARE BENEFITS TO THIS ADDRESS

## Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B? (Circle One)		Yes	No
Full Name: (Please print below the name exactly as it appears on your SSN or Medicare Card)			
Medicare Card Number:		Date of Birth:	
Social Security Number: (if Medicare number is unavailable)		Sex: (circle one)	Female      Male

## Section II

I understand that the information requested below is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Kathie Kime  
Claimant Name (Please Print)

A1606155080-0003  
Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form

Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

## Section III

Kathie Kime  
Claimant Name (Please Print)

A1606155080-0003  
Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Person Completing This Form

Date

# EXHIBIT 4

Sedgwick Claims Management Services, Inc.  
P O Box 14448  
Lexington, KY 40512-4448



June 21, 2016

Kathie Kime  
417 Cappella Drive  
Diamond Springs, CA 95619

RE: Your Claim Number: A1606155080-0003  
Date of Loss: 06/14/2016

Dear Kathie Kime:

As you are claiming loss of wages due to the above referenced incident, it is necessary for us to verify your wage information with your employer. Please complete, sign and return the enclosed Wage Loss Authorization form at your earliest convenience.

Upon receipt of the completed and signed Authorization form, we will attempt to secure and/or verify wage information from your employer. You may help expedite this process by alerting your employer that this request will be coming to their attention.

Should you have any questions in the meantime, please feel free to call me.

Sedgwick manages claims for Sears Holdings Corporation on behalf of ACE American Insurance Company.

Sincerely,

Janet Cozzone  
Claims Representative  
Toll Free Phone: (866)352-1521 x 50694  
Fax: (866)876-7050  
E-mail: janet.cozzone@SedgwickCMS.com

4



**Sedgwick CMS**

Kathie Kime  
417 Cappella Drive  
Diamond Springs CA, 95619

## **PERMISSION TO OBTAIN WAGE INFORMATION**

**I, Kathie Kime, AUTHORIZE** \_\_\_\_\_  
(Employer Name and Address)

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to furnish to any Claims Personnel of Sedgwick Claims Management Services, or anyone acting on their behalf, all information regarding position, job title, hours, compensation, and time lost from work by me before, on or after the accident date of 06/14/2016.

**I FURTHER AUTHORIZE** the Firm or Individual named above to release all medical information as well as all information related to amounts paid or due under any sick leave plan, wage continuation plan or group hospital or accident benefit plan, including the identity and address of the insurance carrier.

**I UNDERSTAND** that this information will be used to determine or to verify the extent of my/his/her loss, and to evaluate my/his/her claim arising out of this accident.

**I AGREE** that this authorization will remain valid until this claim is concluded or unless revoked by delivery of written notice to the above-named insurance company.

**I UNDERSTAND** that I (or my representative) am entitled to receive a copy of this authorization.

A photocopy of this form may be accepted as the original.

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Signature of Employee, Representative, Parent or Guardian

---

Date

Claim # A1606155080-0003

Examiner: Janet Cozzzone

Sedgwick CMS, P.O. Box 95407, Hoffman Estates, IL 60195, Telephone # 866-352-1521 ext. 50694 Fax 866-876-7050

# EXHIBIT 5

Sedgwick Claims Management Services, Inc.  
P O Box 14448  
Lexington, KY 40512-4448



June 21, 2016

Kathie Kime  
417 Cappella Drive  
Diamond Springs, CA 95619

# 000671646  
JULY 18 2017  
Sedgwick

Dear Kathie Kime:

Attached please find a Medical Authorization and Provider List forms must be completed, signed and returned to our office in order for us to obtain medical documentation from the hospital and/or doctor(s) you have treated with.

→ Please note A&E Factory Services does not provide medical payments to health care facilities. As such, you will be responsible for any/all medical bills incurred for the treatment you receive.

We have enclosed a self-addressed envelope for the return of the attached forms. However, should you have any questions concerning this request, please contact me at 866-352-1521 ext. 50694

→ Sedgwick manages claims for Sears Holdings Corporation on behalf of ACE American Insurance Company.

Sincerely,

Janet Cozzone  
Claims Representative  
Toll Free Phone: (866)352-1521 x 50694  
Fax: (866)876-7050  
E-mail: janet.cozzone@SedgwickCMS.com

Enclosure

**AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION**

I authorize each of the parties identified below to use and disclose any and all of my individually identifiable medical or health information, as described below, for purposes of administering my claim. I understand that the information about me that I authorize to be used or disclosed may be re-disclosed in accordance with the terms of this Authorization by the recipient thereof and may no longer be protected by federal or state privacy laws or regulations.

I specifically authorize physicians, nurses and hospitals to communicate my individually identifiable medical or health information by any means, including written or telephonic communications or by direct interview, whether or not I am present during, or notified of, such communications, and I hereby authorize Sedgwick Claims Management Services, Inc. ("Sedgwick") to initiate and conduct such communications whether or not I am present or have received notice thereof.

1. **What Information is covered by this Authorization?** This authorization applies to all medical, health, psychological, and/or psychiatric information, records and reports, including information regarding pre-existing health or medical conditions or illnesses (a) that are in existence while this authorization is valid (see Item 3) and (b) that are related to any of the following: my workers' compensation claim; my claim for disability benefits; my claim for bodily injury; my claim for personal injury; or my claim for dental benefits.

My claim involves the following condition:

My information to be disclosed may include, but is not limited to, medical or health history, chart notes, prescriptions, diagnostic test results, x-ray reports, and records received from other health care providers. If directly related to my claimed condition or illness, this information may include the following, **Please check yes or no and initial:**

HIV test results, HIV or AIDS information.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____
Psychiatric information.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____
Information related to drug or alcohol abuse.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Initial here _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2. **Who may disclose and receive Information under this Authorization?**

A. Any person or facility that attends, treats or examines me,  
including but not limited to

(specific name, if needed) is to make this information

Available to Sedgwick or any of its agents, representatives or independent contractors;  
and

B. When relevant to my claim, Sedgwick may re-disclose (without my further authorization) any and all of my individually identifiable medical or health information (whether obtained pursuant to this authorization or otherwise from any person or entity) to any of the following, (a) Any person or

facility that attends, treats or examines me; (b) Any person or facility that impacts determination of my claim or that coordinates my benefits; (c) My employer and its affiliates and their representatives, independent contractors and service providers that may receive any such information from my employer to the extent permitted by state or federal law; or (d) The Social Security Administration or a social security or vocational rehabilitation vendor. Sedgwick may use my information obtained pursuant to this authorization in any other claim matter that Sedgwick may administer or handle related to me.

3. **How Long this Authorization is Valid?** This authorization is valid during the duration of my claim(s) and any future related claims, unless a different period is required under applicable federal or state law. Release in connection with a claim for benefits for health insurance may not remain valid longer than the term of coverage of the policy; or for the duration of the claim for all other insurance claims.
4. **Revocation of this Authorization.** Unless otherwise provided by federal or state law, I understand that I may revoke this authorization at any time by notifying, in writing, Sedgwick at P O Box 14448 Lexington, KY 40512-4448 of my revocation and that my revocation shall be effective upon Sedgwick receipt of my notice of revocation. I also understand that my revocation of this Authorization will not have any effect on any actions taken by Sedgwick before it's receives my revocation.
5. **Processing of Claims.** I understand that this Authorization is generally necessary for the processing of my claim. Failure to sign this Authorization may impair or impede the processing of my claim.
6. **Refusal To Sign.** I further understand my health care providers will not condition my treatment, payment, enrollment or eligibility on my refusal to sign this Authorization.

I understand that I have the right to request and receive a copy of this authorization. I understand that I have the right to inspect the disclosed information at any time. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Signature of Patient or Patient's Representative  
Kathie Kime  
Printed Name of Patient or Patient's Representative

Representative's Relationship to Patient, if applicable

Date Signed  
Sedgwick 6/2015

[REDACTED]  
Patient's Address

[REDACTED]  
Patient's Social Security Number

[REDACTED]  
First Day Absent

[REDACTED]  
Date of Birth

Sedgwick Claims Management Services, Inc.

#### NOTICE OF STATE FRAUD REQUIREMENTS

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

Sedgwick Claims Management Services, Inc.  
P O Box 14448  
Lexington, KY 40512-4448



June 21, 2016

Kathie Kime  
417 Cappella Drive  
Diamond Springs, CA 95619

Dear Kathie Kime:

NAMES, ADDRESSES & PHONE NUMBERS OF TREATING MEDICAL/DENTAL PROVIDERS

Please indicate in the spaces below the complete names, addresses and phone numbers of all the treating physicians that provided treatment to the claimant.

1) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

2) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

3) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Sincerely,

Janet Cozzone  
Claims Representative  
Toll Free Phone: (866)352-1521 x 50694  
Fax: (866)876-7050  
E-mail: janet.cozzone@SedgwickCMS.com

# EXHIBIT 6

Fax

866-876-705

PROPERTY DAMAGE RELEASE

KNOW ALL MEN BY THESE PRESENTS:

That the Undersigned, being of lawful age, for sole consideration of **One thousand eight hundred sixty five dollars and 93/100 (\$1,865.93)** to be paid to **Kathleen Kime (for property damage only, this release does not include any approved repair supplements)**, do/does hereby and for my/our/its heirs, executors, administrators, successors and assign release, acquit and forever discharge Gregory Williams, A&E Factory Services, Sears, Roebuck and Co., Store #04329 and his, her, their, or its agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims\*, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has/have or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen property damages and the consequences thereof resulting or to result from the occurrence on or about the 14th Day of June, 2016 at or near Missouri Flat Road, Placerville, CA. \* Does not include personal injury claims or actions.

It is understood and agreed that this settlement is the compromise of a doubtful and disputed claim, and that the payment made is not to be construed as an admission of liability on the part of the party or parties hereby released, and that said releases deny liability therefore and intend merely to avoid litigation and buy their peace.

The undersigned further declare(s) and represent(s) that no promise, inducement or agreement not herein expressed has been made to the undersigned, and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

THE UNDERSIGNED HAS READ THE FOREGOING RELEASE AND FULLY UNDERSTANDS IT.  
Each party to this Agreement agrees to bear their own costs and attorney's fees

Signed, sealed and delivered this 18<sup>th</sup> day of August, 2016.



Witness

CAUTION:

READ BEFORE SIGNING BELOW

Kathleen Kime LS  
Kathleen Kime, Claimant

Witness

X \_\_\_\_\_ LS  
Claimant's Spouse (if applicable)

Witness

X \_\_\_\_\_ LS

STATE OF California

CLAIM #: A1606155080-0002

COUNTY OF EI Dorado

EXAMINER: Janet Cozzone

On the \_\_\_\_\_ Day of \_\_\_\_\_, 20\_\_\_\_\_, before me personally appeared

\_\_\_\_\_ to be known to be the person(s) named herein and who  
executed the foregoing Release and \_\_\_\_\_ acknowledged to me that \_\_\_\_\_ voluntarily  
executed the same.

NOTARY PUBLIC

My Term expires \_\_\_\_\_, 20\_\_\_\_\_. 6

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**Sedgwick Claims Management Services, Inc.**  
P O Box 14448  
Lexington, KY 40512-4448

Inc Deposited  
ON 8/31/16 201608311611 Check for car repair +  
\$300. Non-Use 101-2267  
GLE PIECE

**Electronic Service Requested**

5

1

SINGLE PIECE  
2307 0.3820 SP 0.465

KATHLEEN KINE

KATHLEEN KINE

<b>DATE</b>	<b>CHECK AMT</b>	<b>CHECK NO.</b>
08/22/2016	1,865.93	██████████
<b>PAYEE</b>	<b>TAX ID</b>	
KATHLEEN KIME	*****	
<b>SCMS UNIT</b>	<b>PAGE</b>	
183 Sedgwick Claims Management Services, Inc	1 of 1	

Claimant Name	Loss Date	Claim Number
KIME, KATHLEEN	06/14/2016	A1606155080-0002
Amt Paid:	1,865.93	Description: Settlement of all claims
Dates:	06/14/2016-08/19/2016	Comment: Full and final settlement of all property damage claims.

# EXHIBIT 7

November 06, 2018

KATHLEEN KIME  
417 CAPPELLA DRIVE  
DIAMOND SPRING , CA 95619

**VIA CERTIFIED/  
RETURN RECEIPT**

Re: Our File Number: 4F632543790820  
Insured: SEARS HOLDINGS CORPORATION  
Claimant: KATHLEEN KIME  
Date of Accident: 06-14-2016  
Agency #:

Dear Sir or Madam :

With reference to the above captioned matter, enclosed please find a Medicare Information Request form. Federal law requires liability, no-fault, and worker's compensation insurers, and self-insured entities, to obtain and report specific information about claimants who may also be Medicare beneficiaries. This information is reported to The Centers for Medicare and Medicaid Services, the federal agency that administers the Medicare program, for coordination of benefit purposes.

Please complete the enclosed form and return it in the self addressed envelope enclosed or to the address specified at the bottom of this letter. If you are represented by an attorney please forward this correspondence to them.

Thank you for your cooperation.

Sincerely,

*ESIS Claims*

**PLEASE RETURN COMPLETED FORM TO:**

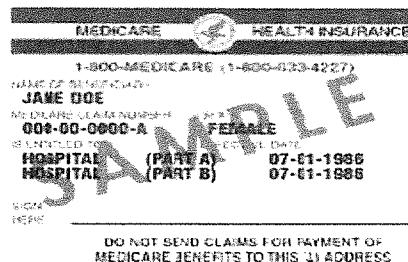
ESIS AGL Claims  
P. O. Box 5127  
Scranton, PA 18505-0559

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



### Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?												<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please complete the following. If no, proceed to Section II.														
Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available.)														
Medicare Claim Number:												Date of Birth (Mo/Day/Year)		
**Social Security Number: (If Medicare Claim Number is Unavailable)												Sex	<input type="checkbox"/> Female	<input type="checkbox"/> Male

\*\*Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

### Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

\_\_\_\_\_  
Claimant Name (Please Print)

4F632543790820  
Claim Number

\_\_\_\_\_  
Name of Person Completing This Form If Claimant is Unable (Please Print)

\_\_\_\_\_  
Signature of Person Completing This Form

\_\_\_\_\_  
Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.